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Conception, pregnancy, and childbirth from the perspective of transgender men: A meta-ethnography

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ABSTRACT

Background: Transgender men who decide to gestate biologically often face a health system that is highly feminized and discriminatory. In addition, the lack of preparation and knowledge among healthcare professionals leads to the provision of care that fails to meet their specific needs.
Aim: To synthesise the experiences of transgender men with regard to conception, pregnancy, and childbirth.
Method: Ten studies were included in a synthesis of qualitative studies, following the interpretive meta-ethnography method developed by Noblit and Hare and summarized in accordance with the eMERGe meta-ethnography reporting guidelines.
Results: The metaphor of *a divergent matryoshka dealing with a constricted reality* helps us to understand the experiences of conception, pregnancy, and childbirth of transgender men, who often face stigma, discrimination, and marginalization in society and healthcare. The metaphor also highlights the gender dysphoria that arises from the physical changes associated with these processes. Four key themes emerge from this metaphor: (1) The decision to conceive being a trans man; (2) The challenge of adjusting to a new body reality; (3) The significance of navigating in an environment of non-representation; and (4) The marked absence of transsexuality in mainstream healthcare.
Conclusions: Actions should prioritize strengthening ethical sensitivities and improve the training of health professionals to address issues such as gender perspectives, equality, and communication skills. Additionally, social visibility policies need to be implemented.

Problem or issue

Transgender men who choose to undergo biological gestation often find themselves in a predominantly female environment that discriminates against their unique needs. As a result, they face stigma, discrimination, and social and health marginalization.

What is already known

Gestational pregnancy in transgender men is becoming increasingly common in certain cultural contexts. However, there is little literature that explores their unique experiences and health professionals may feel discomfort, uninformed, or simply unprepared to provide adequate care.

What this paper adds

This paper sheds light on the experiences of transgender men who undergo biological pregnancies. It emphasizes the importance of enhancing ethical sensitivity and expanding the training of healthcare professionals beyond the binary gender approach.

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1. Introduction

Transmasculine individuals are individuals who identify as male but were assigned female at birth and can become pregnant and breastfeed as they kept their reproductive anatomy and uterus [1]. Transpeople faces frequent violations of their basic rights and is often considered vulnerable in society. They are labelled as "immoral" or "scandalous," highlighting the discrimination, segregation, and marginalization they experience. [2,3].

This also applies to the healthcare field, where transmasculine individuals may face disempowerment through stigma, discrimination, and prejudice, as well as experiencing various health disparities [4]. This issue becomes more critical in the context of reproductive health, particularly in Western cultures where transgender individuals are legally recognized [5]. They typically face an exclusively female environment, with cultural norms and expectations that generate constant problems to achieve their reproductive objective. This often results in inappropriate and intrusive behaviour, harassment, incitement to hatred, as well as legal, health, psychological, physical, and economic violence [6,7].

This is further exacerbated by misinformation and a lack of adequate preparation of healthcare professionals [8]. During conception, pregnancy, and childbirth, transgender men may have specific physical needs due to biomedical effects of prior or anticipated use of exogenous hormones or gender-affirming surgeries, which require special attention and care [1]. Additionally, pregnancy can have an impact on their mental health [1,9]. International research suggests that transgender individuals are at higher risk for peripartum depression due to increased gender dysphoria [8,10,11]. This group has higher rates of baseline depression and suicide compared to the general population. Pregnancy and childbirth can be especially distressing for them, leading to increased isolation and gender dysphoria [8,11]. Nursing and midwifery professionals have the potential to establish a bond as people who care, providing comfort, support, and accompaniment to future families. The level of care directly affects the long-term emotional outcome of the person and their family members [12]. However, previous studies have shown that these professionals may feel discomfort, lack of knowledge, and general difficulties in understanding this population group [13].

Despite the growing numbers of gestational pregnancies in transgender men, there are only few studies that have explored their unique experiences [14,15]. With this article, we aim to narrow this knowledge gap by synthesising 10 qualitative studies on the experiences of transgender men during conception, pregnancy, and childbirth.

2. Methods

We conducted a meta-ethnography following the seven steps described by Noblit and Hare (1988)[16], combining results of previous qualitative studies in an interpretative way, via an inductive process and systematic comparison to gain deeper insights into underlying conceptual and theoretical basis. In addition, we adhered to the eMERGe reporting guidelines [17] to improve the quality, transparency, and completeness of the study.

2.1. Search methods

SFB and JCLQ conducted a comprehensive and systematic search of studies published up until December 2022. The search strategy was developed according to the phenomenon of interest (pregnancy) and purpose/evaluation (experiences) of the present study, as we all as the target sample group (transgender men) and type of research (qualitative research). Search terms and medical subject headings were combined using both OR and AND, using truncations to broaden the search (Supplementary File 1).

Inclusion criteria were: Original qualitative articles or mixed-methods articles written in English, Spanish or Portuguese reporting the experiences of transgender men during conception, pregnancy, and/or childbirth. Gray literature, discussion articles, and review articles were excluded.

2.2. Search outcomes

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) [18] flowchart (Fig. 1) describes the filtering process used in this study. A total of 747 records were identified in the PubMed, Scopus, CINAHL, PsycINFO, and Web of Sciences databases. After removal of 284 duplicates, 49 articles from a pool of 463 records were pre-selected based on title and abstract. A complete read of all pre-selected articles resulted in the final inclusion of 10 articles. The selection process was overseen by SFB and JCLQ, although consensus meetings were held with all authors.

2.3. Quality appraisal

Each paper was critically appraised using the Critical Appraisal Skills Program (CASP) tool[19]. General assessment indicated the articles were of high quality regarding their goals, designs, analyses, and results (Table 1). JCLQ performed the initial evaluation, and the results were discussed with SFB and MJMF.

2.4. Data extraction and synthesis

A critical reading of the 10 included studies was carried out. The data extraction and synthesis were carried out by JCLQ and supervised by SFB, MJMF and ERM (step 4). The analysis began with the article containing the largest amount of data [20]. First-order (participants quotes) and second-order (interpretations by authors)[21] constructs were extracted from each article and recorded in tables. These tables included the constructs, a brief description of each construct, and the line-by-line code. Through intra- and inter-study comparisons (using the data shown in Table 2) we identified similarities and differences, which led to the formulation of new concepts or the adoption of existing concepts.

Translation tables allowed the incorporation of the findings of the studies with each other through analogous translations (concepts in one study can incorporate those of another) and refutational translations (concepts in different studies contradict each other) to form new concepts of third order [21] (step 5). We employed an inductive synthesis process and discussed the results during the write-up (step 6). Through an in-depth analysis, going back and forth between translations and original studies, we created a synthesis of lines of argument based on metaphorical themes based on consensus meetings of all authors.

The results of this synthesis were evaluated using the Confidence in the Evidence from Reviews of Qualitative research (CERQual) tool [22] (Table 3).

3. Results

Ten original articles from Sweden (n=4), Canada (n=3), the United States (n=2), and Australia (n=1) were included in the analysis. The number of participants in each study ranged from 1 to 25, involving a total of 146 transgender men who were or had been pregnant. The studies employed mixed and qualitative methodological designs with approaches based on phenomenology, grounded theory, the biographic method, or autobiography. Data were collected through interviews (individual or in pairs, in-depth or semi-structured, and online or face-to-face) and a biographical experience (Table 2).

The metaphor *a divergent matryoshka dealing with a constricted reality* (Fig. 2) emerged from reciprocal translations as a fitting representation of the problems faced by transgender men during conception, pregnancy, and childbirth. The matryoshka is a traditional wooden toy consisting of a hollow doll that opens to reveal smaller identical dolls inside. Originally it symbolized traditional motherhood and fertility.

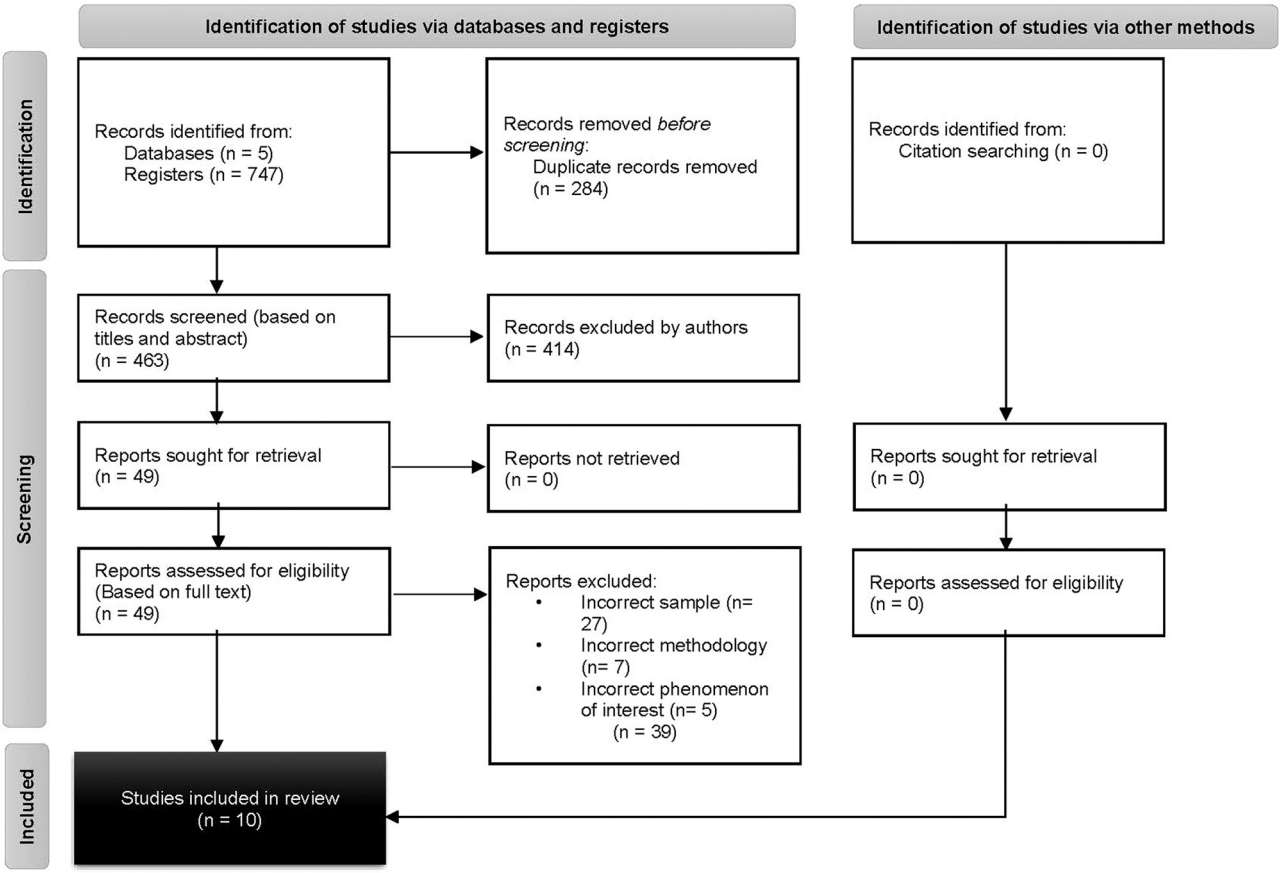

Fig. 1. PRISMA flowchart.

Table 1
Quality assessment of included studies.

Articles	Questions									
	1	2	3	4	5	6	7	8	9	10
Charter et al. (2018)	✓	✓	✓	✓	✓	-	✓	✓	✓	✓
Ellis et al. (2015)	✓	✓	✓	-	✓	-	✓	✓	✓	✓
Falck et al. (2020)	✓	✓	✓	✓	✓	-	✓	✓	✓	✓
Hoffkling et al. (2017)	✓	✓	✓	✓	✓	-	✓	✓	✓	×
Kirczenow et al. (2020)	✓	✓	✓	✓	✓	-	✓	✓	✓	✓
MacDonald et al. (2016)	✓	✓	✓	✓	✓	-	✓	✓	✓	-
Malmquist & Nieminen (2021)	✓	✓	✓	✓	✓	-	✓	✓	-	-
Malmquist et al. (2019)	✓	✓	-	✓	✓	-	✓	✓	✓	-
Malmquist et al. (2021)	✓	✓	✓	✓	✓	-	✓	✓	-	-
Richardson et al. (2019)	✓	✓	✓	-	-	-	-	-	-	✓

Abbreviations: ✓ Yes – Unclear × No; Critical appraisal questions: 1) Was there a clear statement of the aims of the research? 2) Is the qualitative methodology appropriate? 3) Was the research design appropriate to address the aims of the research? 4) Was the recruitment strategy appropriate? 5) Were the data collected in a way that addressed the research issue? 6) Has the relationship between researcher and participants been adequately considered? 7) Have ethical issues been taken into consideration? 8) Was the data analysis sufficiently rigorous? 9) Is there a clear statement of findings? 10) How valuable is the research?

Our divergent matryoshka represents the break with associating motherhood exclusively with the normative cisgender woman. It allows us to represent the different layers and complexities that trans men experience during the process of conception, pregnancy, and birth. Often, the health system and society only recognize and support the outward layer of the matryoshka, while the other identities lead to conflicts as they do not align with the expected stereotypes for this process. The metaphor is supported by 4 main themes: [1] *The decision to conceive being a trans man,* which involves rejecting the traditional roles of womanhood and the idealized motherhood, thereby challenging social norms while having only limited options available to pursue transgender parenthood; [2] *The conflict arising from the new bodily reality,* as gender dysphoria is experienced due to changes in physical appearance during pregnancy and the suspension of testosterone consumption; [3] *The meaning assigned to a scenario of non-representation,* expressing the feelings of social exclusion, prejudice, and pressure experienced during pregnancy; and [4] *The lack of incorporating transsexuality into healthcare*, evidenced by the inexperience and limited knowledge of healthcare professionals.

CERQual assessment [22] showed high confidence in themes 1, 2, and 4, and moderate confidence on theme 3, suggesting that these results provide a reasonable representation of the phenomenon of interest (Table 3).

3.1. *Deciding to conceive being a trans man*

Conceiving and achieving pregnancy remains challenging for transgender men as they face social prejudices. Making the decision to conceive was confronted with a societal expectation of femininity by which maternity and the traditional roles of women are imposed as a measure of feminine success, failing to acknowledge the reality of transgender men [23]. The process of making the decision to become pregnant was often accompanied by feelings of ambiguity, loneliness, overwhelm, and an internal struggle requiring negotiating their masculine identities. As they had no similar experiences to draw on, participants had to develop strategies to manage these emotions and confusion [9,20,24].

Some transgender men have expressed a clear and unwavering desire to have a biological child due to the importance they place on genetic

Table 2
Paper characteristics.

Authors, (year), Location	Methods	Aim	Sample	Data collection method	Key findings
Charter et al. (2018) Australia	Mixed-methods research	To address how Australian trans men construct and experience their desire for fatherhood, and how Australian trans men construct and experience gestational pregnancy	25 trans men	One-on-one interviews	Three major were: (1) Perspectives on parenting, which consisted of two subthemes: "Growing up female: The assumption of motherhood" and "Orientating toward fatherhood: Parenting on my own terms"; (2) Pursuing pregnancy, which consisted of three subthemes: "A functional sacrifice," "The struggle: Living without T," and "Accessing reproductive assistance"; and (3) The pregnant man, which consisted of three subthemes: "Inhabiting the pregnant body," "Chest distress," and "The Isolation of Exclusion." Parenthood was initially described as alienating and complex, however transitioning enabled participants to negotiate and construct their own parenting identity. Pregnancy was positioned as a problematic but "functional sacrifice," however formal assisted fertility experiences were rife with exclusion. At the same time dysphoria associated with withdrawing from testosterone and the growing fecund body were significantly troubling. Changes to the chest were of particular concern for participants. Exclusion, isolation, and loneliness were the predominant features of trans men's experiences of gestational pregnancies. Healthcare systems are not generally supportive of trans bodies and identities and trans men encounter significant issues when interacting with healthcare providers
Ellis et al. (2015) USA	Grounded theory	To explore the conception, pregnancy, and childbirth perspectives of male and gender-variant gestational parents who have undergone social or medical gender transition prior to pregnancy.	8 individuals	Individual interviews	Loneliness was the overarching theme that permeated all participants' experiences, social interactions, and emotional responses through every stage of achieving gestational parenthood. Within this context of loneliness, which surfaces repeatedly throughout participant narratives, participants described complex internal and external processes of navigating identity.
Falck et al. (2020) Sweden	Qualitative study (inductive thematic content analysis)	To investigate how trans masculine individuals experience healthcare encounters in connection with pregnancy, delivery, and nursing, in a setting where mandatory sterilization to change legal gender was recently removed	12 trans masculine individuals	In-depth face-to-face interviews	The main category *Expectations and experiences of pregnancy related care* highlights participant expectations of healthcare in relation to gender norms concerning pregnancy and perceptions of received care. The actions that participants took to ensure that their health needs were fulfilled are presented in the second main category: *Maneuvering to ensure needs*.
Hoffkling et al. (2017) USA	Grounded theory	To identify some of the needs of transgender men in the family planning process and during the peripartum period, as well as the ways they have achieved empowerment, opportunities for supporting their further empowerment, and priorities for further investigation through a systematic qualitative study	10 transgender men	Online interviews	Participants reported diverse experiences and values on issues including prioritization and sequencing of transition versus reproduction, empowerment in healthcare, desire for external affirmation of their gender and/or pregnancy, access to social supports, and degree of outness as male, transgender, or pregnant. We identified structural barriers that disempowered participants and describe healthcare components that

(*continued on next page*)

Table 2 (*continued*)

Authors, (year), Location	Methods	Aim	Sample	Data collection method	Key findings
					felt safe and empowering. We describe how patients' strategies, and providers' behaviours, affected empowerment. Anticipatory guidance from providers was central in promoting security and empowerment for these individuals as patients.
Kirczenow et al. (2020) Canada	-	To explore the experiences of transmasculine individuals with pregnancy and birth	22 transmasculine individuals	In-depth, semi-structured interviews	The interviews focused on stories about how the study participants built their families and navigated health care systems in the context of being pregnant transgender persons. As part of a larger study that considered the pregnancy, birth and infant feeding experiences of transmasculine individuals, this paper examines three themes that emerged from the narratives: experiences of gender dysphoria, addressing the gender binary, and intersectionality.
MacDonald et al. (2016) Canada	Qualitative study (interpretive description methodology)	1) To describe transmasculine individuals' experiences with their chests, lactation, and chestfeeding; 2) To inform transmasculine individuals who might want to chestfeed their babies; 3) To guide health care professionals (e.g., lactation consultants, midwives, nurses, physicians, and surgeons) who provide breast and chest care.	22 Participants who self-identified as transmasculine and had experienced or were experiencing pregnancy, birth, and infant feeding	Semi-structured interviews	Out of 22 participants, 16 chose to chestfeed for some period of time, four participants did not attempt chestfeeding, and two had not reached the point of infant feeding (i.e., were still pregnant or had a miscarriage). Nine of the 22 study participants had chest masculinization surgery before conceiving their babies. Six participants had the surgery after their children were born, five desired the surgery in the future, and two did not want it at all. Chest care, lactation, and chestfeeding in the context of being a transgender person are reported in this paper. The participants' experiences of gender dysphoria, chest masculinization surgery before pregnancy or after weaning, accessing lactation care as a transmasculine person, and the question of restarting testosterone emerged as data.
Malmquist & Nieminen (2021) Sweden	Qualitative study (thematic analysis)	To explore how lesbian, bisexual and transgender couples people negotiate the question of who gives birth, in couples with two potential birth parents, and where one or both partners have a pronounced fear of childbirth	17 self-identified lesbian, bisexual and transgender people	Semi-structured interviews	Fear of childbirth was negotiated as one of many aspects that contributed to the decision of who would be the birth-giving partner. Several participants decided to become pregnant despite their fears, due to a desire to be the genetic parent. Others negotiated with their partner about who was least vulnerable, which led some of them to become pregnant despite fear of childbirth. Still other participants decided to refrain from pregnancy, due to fear of childbirth, and were delighted that their partner would give birth. Several participants described their partner's birth-giving as a traumatic experience for them, sometimes also when the birth did not require any obstetric interventions. The partner's experience was in some cases not addressed in postnatal care.
Malmquist et al. (2019) Sweden	Qualitative study (thematic analysis from a critical realistic epistemology)	To explore and describe thoughts about and experiences of pregnancy, childbirth and reproductive healthcare in lesbian and bisexual women and transgender people with an expressed fear of childbirth.	17 self-identified lesbian, bisexual and transgender people	Semi-structured interviews	Some participants have not "just "experienced indelicate questions or hetero- or CIS- normative assumptions. Rather, they described previous experiences of healthcare where they were exposed to transphobic or homo- phobic hatred or contempt, to a degree that they had little trust in healthcare staff in general, and a hypervigilance for

(*continued on next page*)

Table 2 (*continued*)

Authors, (year), Location	Methods	Aim	Sample	Data collection method	Key findings
					deficient treatment. In addition to their general fear of childbirth, these experiences can make pregnancy and childbirth an enormous challenge. Therefore, these people need particularly sensitive and professional care.
Malmquist et al. (2021) Sweden	Qualitative study (thematic analysis)	To explore and describe norms concerning maternity, femininity and cisgender in lesbian and bisexual women and transgender people assigned female at birth, with an expressed fear of childbirth.	17 self-identified lesbian, bisexual and transgender people	Semi-structured interviews	Norms concerning maternity and "natural" birth were raised by most participants as an aspect of their fear of childbirth, and about half of the participants described ideals of femininity and/or cisgender as stressful in relation to (the thought of) themselves giving birth.
Richardson et al. (2019) Canada	Hypothetical case scenario (Queer phenomenology)	1. By presenting an analysis of a hypothetical case reflecting a clinical scenario in which a male-identified patient experiences labour and birth, we will provide insight on the institutional barriers faced by transgender males that currently exist in perinatal clinical care areas. 2. Identify pragmatic strategies for nurses and midwives to enhance gender-diverse care in general and gendered clinical areas.			

Abbreviations: United States of America (USA); No information (-)

parenthood [20,25]. This sentiment is captured in the following quote:

> We'd had some close friends who'd really struggled with not being genetically related to their kids… it really made an impression on me and (my partner)… so we decided we'd take turns having a baby [20]

In some instances, participants chose to become pregnant because their cisgender partners had health or fertility problems[20]. Others saw biological conception as a means to become a parent or to feel more connected to their genetically feminine body, seeking social association with women [9,23,24], as this participant expressed:

> [Before coming out to myself or others as transgender] I had a lot of magical thinking about pregnancy and what pregnancy could do. And I think it has a lot to do with the messages that are out there about birth. That pregnancy and birth are like this thing that's gonna connect you with all of womankind for all of history and that it's sort of like the most powerful thing you can do with this type of body. That applies to pregnancy and birth and then it applies further to nursing. And I'm talking about like the conversations we have societally around these things, and like I bought it – hook, line and sinker. I was like, this, this is the answer, clearly because I feel really disconnected from my body. There's something off … this [pregnancy, birth, and breastfeeding] is gonna fix it" [23]

They faced social and economic barriers and encountered difficulties in accessing healthcare and decision support [9,20,24]. Assisted reproduction clinics rejected them on several occasions, and some experienced discrimination when pursuing surrogacy or adoption. As a result, these individuals therefore had to resort to less conventional methods to achieve conception, such as by using known donors or pretending to be a woman [20,24,25].

> I went to this doctor… to sign the form to get donor sperm…and he made me see the clinic psychologist to gauge whether or not I'd be fit as a parent. And so she saw me and [my spouse]. And then after that it went to their ethics board, and the ethics board said that they weren't going to treat us. So [the doctor] turned us away. [24]

Although they often felt isolated and rejected, they were occasionally surprised to find support from family, friends, and even strangers. They also received support from queer and other communities, Facebook groups, and by learning about the experiences of other transgender men who had gone through the same process [24].

3.2. *Challenges posed by a new body reality*

A dominant theme in this study was the conflict that arose from the physical and psychological changes experienced during pregnancy. Once the decision to conceive has been taken, the first step is to stop taking hormone therapy. The resulting physical changes and loss of masculinization caused significant difficulties to transgender men, who suddenly found themselves confronted again with feelings of being at odds with their bodies, especially in men who had not undergone any genital surgery before their pregnancies [20,23,24]. Pregnancy-related changes in their physical appearance together with the "feminization" of the body (muscle loss, increased fat reserves, or the softening of the voice) aggravated the feelings of isolation, stress, anxiety, discomfort, and rejection. If conception was not immediate, these feelings could persist for a long time [20]. In contrast, other participants understood their pregnancy as transcending the typical binary gender roles, refusing to categorize it as female or male, while some related their physical changes to the Viking stereotype, allowing them to feel more masculine with the pregnancy [23], as reflected in the following quote:

> It was never something that seemed discordant with being trans or being male. I was describing it to someone the other day and just said that I won the uterus lottery. I kind of feel like that's, you know, I'm just, I got lucky… for me it was a very kind of traditionally masculine experience in that I was you know like sweaty and hungry and cranky, I mean sort of like stereotype Viking… I was building something which is sort of considered, that is sort of typified as a masculine thing or characterized as a masculine thing, so for me I think I felt more masculine [while] pregnant than I ever had before which was surprising to me. [23]

Pregnancy-related breast augmentation was particularly challenging

Table 3
Confidence in the Evidence from Reviews of Qualitative research (CERQual) evidence profile.

Summary of review findings	Studies contributing to the review findings	Methodological limitations	Coherence	Relevance	Adequacy of data	Overall CERQual assessment of confidence	Explanation of decision
The decision to conceive being a trans man	Charter et al., 2018; Ellis et al., 2015; Hoffkling et al., 2017; Kirczenow et al., 2020; Malmquist et al., 2021	Moderate concerns regarding methodological limitations, as there is insufficient clarity regarding the relationship of the researcher and the participants, as well as their possible influence during the data collection and analysis phases	Minor concerns regarding coherence, as data from primary articles and findings are consistent	Minor concerns about relevance	No or very little concern about adequacy of data (rich data support this finding)	High confidence	Minor concerns about coherence, and relevance; Very minor concerns about adequacy of data; Moderate concerns about methodological limitations
Challenges posed by a new body reality	Charter et al., 2018; Ellis et al., 2015; Hoffkling et al., 2017; Kirczenow et al., 2020; MacDonald et al., 2016; Malmquist & Nieminen, 2021	Moderate concerns regarding methodological limitations, as there is insufficient clarity regarding the relationship of the researcher and the participants, as well as their possible influence during the data collection and analysis phases	Minor concerns regarding coherence, as data from primary articles and findings are consistent	Minor concerns about relevance, since the situations were very similar in all the articles	No or very little concern about adequacy of data (rich data support this finding)	High confidence	Minor concerns about coherence, and relevance; Very minor concerns about adequacy of data; Moderate concerns about methodological limitations
Creating meaning in an environment of non-representation	Charter et al., 2018; Ellis et al., 2015; Hoffkling et al., 2017	Moderate concerns regarding methodological limitations, as there is insufficient clarity regarding the relationship of the researcher and the participants, as well as their possible influence during the data collection and analysis phases	Minor concerns regarding coherence, as data from primary articles and findings are consistent	Minor concerns about relevance, since the situations were very similar in all the articles	Moderate concerns about adequacy of data	Moderate confidence	Minor concerns about coherence, and relevance; Moderate concerns about adequacy of data and methodological limitations
Transsexuality and its absence from healthcare	Charter et al., 2018; Ellis et al., 2015; Falck et al., 2020; Hoffkling et al., 2017; Kirczenow MacDonald et al., 2020; Malmquist & Nieminen, 2021; Malmquist et al., 2021; Richardson et al., 2019	Moderate concerns regarding methodological limitations, as there is insufficient clarity regarding the relationship of the researcher and the participants, as well as their possible influence during the data collection and analysis phases	Minor concerns regarding coherence, as data from primary articles and findings are consistent	Minor concerns about relevance, since the articles incorporate experiences related to meetings with health professionals	No or very little concern about adequacy of data (rich data support this finding)	High confidence	Minor concerns about coherence, and relevance; Very minor concerns about adequacy of data; Moderate concerns about methodological limitations

*Definitions of levels of confidence from the CERQual evaluation (Lewin et al., 2015):

- **High confidence**: It is highly likely that the review finding is a reasonable representation of the phenomenon of interest.
- **Moderate confidence**: It is likely that the review finding is a reasonable representation of the phenomenon of interest.
- **Low confidence**: It is possible that the review finding is a reasonable representation of the phenomenon of interest.
- **Very low confidence**: It is not clear whether the review finding is a reasonable representation of the phenomenon of interest.

and stressful, as breasts were considered the physical attribute that most conflicted with their masculine gender identity, causing them to feel sick, self-loathing toward their appearance, and extreme discomfort [20]. Many participants tried to conceal their chests with bandages or tight garments. In situations where this technique became too uncomfortable, chest surgery was considered, even before the pregnancy had been conceived [26].

> [My chest] was huge and leaky after I had [my child]. It was so horrible and totally stressed me out… I couldn't bind because it was way too painful… it was also right in the middle of summer and it was so hot. I couldn't cover up, I couldn't bind. I ended up just staying home for months, which sounds simple but it was super isolating. [20]

Those participants who had not undergone chest surgery prior to their pregnancies, and wanted to breastfeed, may have postponed this intervention until postpartum or after weaning, often considering it as a reward for having accomplished their personal goal of conceiving a child and having made the commitment to breastfeed. Among those participants who had performed breast reduction surgery, some were still able to produce milk and breastfeed their children, while others could not. Only some did not experience bloating or lactation [20,24,26].

Those choosing to breastfeed did so because they wanted to feel more attached to the baby, and partly due to input from friends and family or recommendations by healthcare professionals [26]. If they were unable to breastfeed, or experienced what they perceived as intrusive behaviour (e.g., having their breasts touched by healthcare professionals without having given their consent), often led to increased gender dysphoria and their desire to speed up their transition. In some cases, breastfeeding was even imposed from the outside [24,26] as highlighted by the following

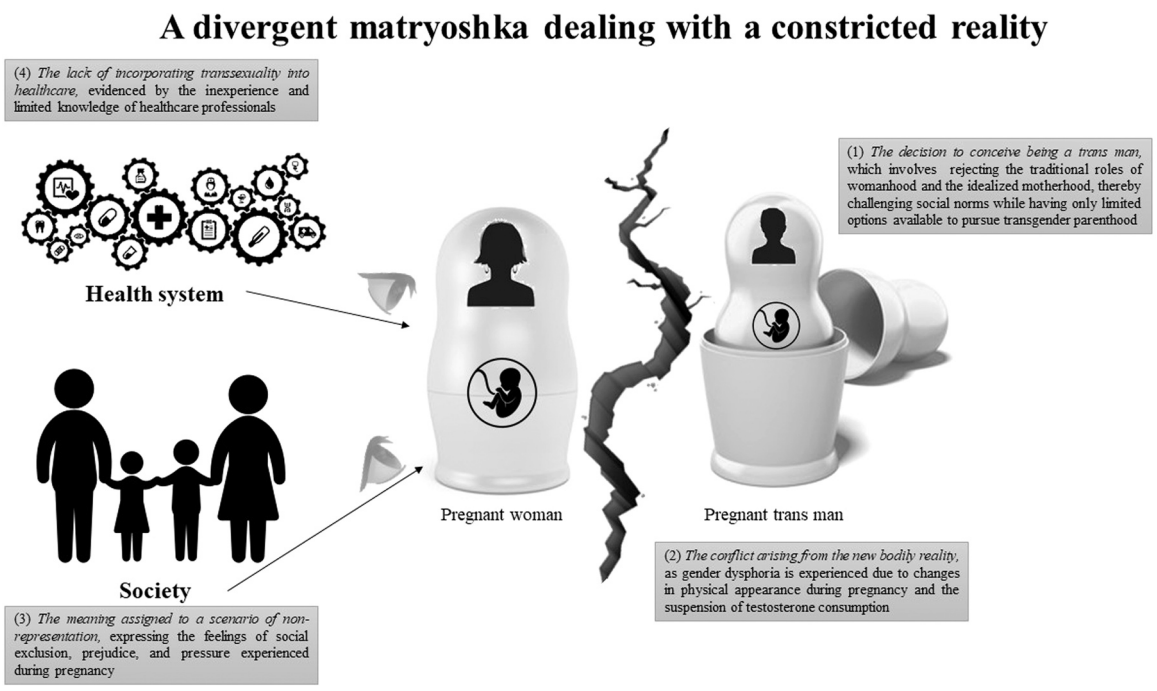

Fig. 2. A divergent matryoshka dealing with a constricted reality.

quote:

> My lawyer very strongly suggested that I do it because it's a very… if you're breastfeeding the child they [social services] are less likely to take it away from you. So she [lawyer] very much pushed, 'You have to breastfeed—you have to prove that you're breastfeeding. If possible do it in front of the social workers when they come around.' I was just, like, I'd really rather not. I planned on pumping and then giving the child the breast milk but not actually full on doing it. But I had to. [26]

If a participant suffered a pregnancy loss, this typically increased the period of personal crisis and added pressure to achieve a pregnancy, as they felt like they were losing control over themselves and being betrayed by their own bodies. Moreover, these psychological changes caused them unexpected suffering that implied an alteration in their well-being [9].

> The hardest part for me was when I was trying to use my body… the way it was supposed to work, and it wasn't working… I felt betrayed—like, I was supposed to be female and females are supposed to have babies, and here I was trying to have a baby and we would get pregnant and then I would have a miscarriage. [9]

Managing the perceptions of others and deciding when and how to reveal their reality was a difficult decision for most participants [9,24]. As a result, only a few individuals chose to openly disclose their transgender identity while pregnant as they feared facing more transphobic violence and discrimination, which is why some chose to impersonate a woman. Others chose not to disclose their reality and posed as cisgender women instead, as this was perceived as reducing the risk of exposure to transphobic violence. However, such impersonations would often intensify their gender dysphoria. Many participants simply chose to conceal their condition or to mislead others into thinking that they were overweight cisgender men. However, by deciding to hide their pregnancies, they lost some benefits such as social support, physical assistance, and external affirmation [24].

> [I was] intentionally trying to be inconspicuous and fly below the radar. I wanted to be able to present as male, but I made that decision [to present as female] at that time because I was afraid [24]

The decision of whether or not to disclose the pregnancy was usually based on their immediate social context. If they chose to conceal it, they usually employed a variety of strategies to avoid judgment from others, such as growing beards, dressing in baggy clothing, or restricting their social interactions [27].

3.3. Creating meaning in an environment of non-representation

The meaning construction process was characterized by transphobia and/or the erasure of the transgender community. One way in which participants were disempowered was through the production of speech that made a pregnant man seem incomprehensible. In most cases, pregnancy was associated with functional and physical sacrifices and the absence of representation was a key factor in fostering exclusion [24]. The lack of comparable experiences contributed to feelings of isolation and loneliness. However, there were cases where the opposite effect occurred with men actively challenging prejudice by openly displaying their pregnancy in public [9,20].

> I can't express how lonely it was to go through a whole pregnancy in hiding. I couldn't be 'out' as a pregnant person and it was really hard. Like, yes my friends and family knew but to the rest of the world I had to hide it to protect my own safety and my mental health from strangers. The loneliness was profound [20]

While, most pregnancies were accompanied by feelings of loss of self and of being disconnected from the foetus, some experienced a sense of embodiment, peace, and a connection with the foetus, their own body, and with their trans or feminine side, even more so than before the pregnancy [9,20].

> This whole process has made me more, I guess at peace with my own body and even with how I was born… I'm more accepting of the trans part of myself, or the female part of myself… The whole pregnancy and birth has made me more whole and more comfortable in my own skin, more comfortable with myself and my past [9]

3.4. Transsexuality and its absence from healthcare

Healthcare professionals play important roles as they shaped the experiences of transgender men who seek conception and go through pregnancy and childbirth. Many studies highlighted the lack of adequate structures and essential support to allow healthcare professionals to attend to the unique needs of transgender people, who often felt rejected and invisible [20,24,28]. In addition, the entire physical space, room decorations, and educational materials exclusively catered to the needs of women [24].

Many studies reported that transgender men experienced transphobic and rude behaviour from healthcare staff. In addition, some were denied care altogether or partially (e.g., breastfeeding training), while being at the receiving end of derogatory comments or even threats to remove their children [23]. This often required strategic skills and knowledge of healthcare routines to manoeuvre the existing power imbalances, which was taxing and often left the individuals feeling vulnerable [29]. In addition, it created an environment of mistrust as some fear to receive a lower level of care. As this added an additional level of fear to the fear of childbirth, some participants opted for home birth [23,24,27].

While some participants reported of having received a level of care that was in line with their expectations, this was often attributed to the efforts of an individual physician rather than to the system as a whole [9,29,30]. Transgender men valued that health professionals were able to answer their biomedical questions about specific transgender situations, however, what seemed equally important was that they were accepted and respected for who they were, that they were not exposed to uncomfortable questions, and that their name and pronouns were used correctly [24], as illustrated by the following quote:

> And they were, like, super-conscientious about it. Like we were off on the side where people wouldn't be barging in. And they were consulting me before anybody came in the room. And they were using the right pronouns. And they were not weird about it. They didn't ask me any weird questions. It was just unbelievable. I was just kind of blown away at how good they were about it [24]

4. Discussion

By analysing 10 qualitative studies on the experiences of transgender men during pregnancy, the metaphor of *a divergent matryoshka dealing with a constricted reality* emerged (Fig. 2), symbolizing the experiences of conception, pregnancy, and childbirth among transgender men. This metaphor represents how transgender men navigate the heteronormative society in which they must build their parenting processes. In this society, gender roles and behaviours have historically been understood as binary, i.e., either masculine or feminine. These gender norms shape the expectations and social understandings of pregnancy, birth, and child rearing. As a result, pregnant transgender men face healthcare contexts that are ill-equipped to deal with their specific needs, often leading to exclusion and marginalization, and the need to constantly have to explain themselves and reaffirm their gender identities [8,14,24,31,32]. Furthermore, while society as a whole negotiates public and private identities based on an established model of heterosexual development; individuals with sexual and gender identities that do not conform to prescribed norms must privately negotiate their identity [33].

The pregnant body is a powerful symbol that is strongly rooted in the construction of the female gender. Therefore, transgender men challenge these established constructs of "motherhood" and "fatherhood" within the family context [20,34]. This challenge also extends to the gender constructs prevailing among healthcare professionals, who have their own attitudes and assumptions which then shape the type and level of care they provide in these situations, which may result in overt discrimination [35]. However, most transgender men encountered healthcare professionals that had not been adequately trained and prepared to deal with their specific needs, which left them feeling insecure and ambivalent when interacting with those caregivers and the system as a whole [35,36]. In some cases, the decision not to disclose sexual orientation was reported due to concerns about discrimination and marginalization by midwives [37]. Furthermore, the heteronormative culture and lack of cultural competence that exists in midwifery practice results in the needs of this group being misunderstood or ignored [36,38]. This often caused suffering as they had to deal with social expectations and unprepared health personnel, which complicated conception, pregnancy, and birth. In caring science [39], suffering is one of the main ontological concepts related to illness, care, and life. In this case, the suffering was related to care which always causes a violation of the person's dignity. In addition, conception, pregnancy, childbirth, and the puerperium were accompanied by challenges associated with their ambiguous gender identity and the reappearance of feminine attributes which they had long struggled to hide. In terms of the Caritative Caring Theory [40], people can distance themselves from a reconciliation with their identity and bodily reality, which brings them closer to suffering.

The concept of whole care means that caregivers need to put aside their prejudices [40]. However, in this particular instance, the care they had to provide may have challenged their *ethos* and *cáritas*, because it could violate their ideal projections of social constructs and contradict accepted reproductive and gender norms [41]. The concept of *cáritas* is related to the involvement of health professionals in the suffering of transgender men, while *ethos* is related to their sense of professional duty, which implies prioritizing the integrity of the person being cared for. Both the literature as a whole, and the 10 studies reviewed here, show that most healthcare professionals do not receive any or only inadequate training with regard to the reproductive health of transgender people [8,28,42,43].

4.1. Implications for practice and/or policy

Our findings have highlighted the urgent need to strengthen education, practice, and research to achieve a more comprehensive level of care for transgender men who wish to gestate biologically.

The education and training of healthcare professionals should encompass the specific needs of all minority groups, including the LGTBIQ+ community, to foster awareness and tolerance of other realities that may lie outside a person's personal reference frame. Specifically, midwives are supposed to promote, protect, and support sexual and reproductive health, and respect cultural diversity and human dignity [44]. However, some midwifery professionals report that they lack experience and knowledge on how to best support transgender men in the process of conception, pregnancy, and childbirth, and this hinders the provision of comprehensive care. Contemporary midwifery education related to LGTBIQ+ populations of childbearing age may be inadequate and needs development, and national modules are currently proposed that bring together educational objectives to challenge and expand knowledge, attitudes and beliefs regarding LGTBIQ+ terminology and health needs [38].

These educational efforts should not be limited to future midwives and nurses but include those already in active service. It is important to include aspects such as the gender perspectives, equality, and communication skills. Also ethical training is important to equip professionals with a sensitivity for the ethical dimensions of their work and provide them with an understanding of the ethical aspects of care [45].

In clinical practice, it is necessary to establish policies to give this group a greater visibility.

Further studies are needed to gain a better understanding of the specific needs of minority groups, a prerequisite before these needs can be incorporated into clinical practise.

4.2. Strengths and limitations

The use of a meta-ethnographic approach, based on the method developed by Noblit and Hare[16], has allowed for the synthesis and generation of new ideas and knowledge through an inductive process, while preserving the original meaning [46]. Our extensive literature search only yielded articles in English and from 4 countries, namely Sweden, Canada, USA, and Australia, where transgender men have a greater visibility compared to most other countries in the world. This highlights the need to conduct additional studies in different geographical contexts and with different healthcare and social characteristics.

Nevertheless, the selected studies were evaluated with the CASP[19] tool, which allowed us to judge the methodological quality of the included articles. This was complemented by the eMERGe Reporting Guidance[17] and CERQual[22] tools to further strengthen the reliability of our findings so it can serve as a basis for decision makers, applications in clinical settings, and for future research.

5. Conclusions

In this meta-ethnography we synthesised the experiences of transgender men during conception, pregnancy, and childbirth which seemed to be adequately captured by the emerging metaphor of *a divergent matryoshka dealing with a constricted reality*. Transgender men experience this as a constant to-and-fro process between their male and female identities, as they transgress the social norms established for pregnancy and those related to femininity and/or cisgender. Transgender men often face stigma, discrimination, and social and health marginalization, which pose severe challenges for the already difficult process of conception and subsequent pregnancy and childbirth, forcing transgender men to additionally deal with issues of gender dysphoria.

The findings presented here, highlight these different realities that fall outside the bounds of heteronormativity. These issues can only be addressed by adapting the training of future healthcare professionals, sensitizing them to realities that go beyond the binary gender norm and allowing them to overcome potential sentiments of transphobia and prejudices regarding gender stereotypes. This must be accompanied by social policies to increase the visibility and acceptance of this group in society as a whole.

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Declaration of Competing Interest

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2024.101659.

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